UNITED STATE BANKRUPTCY COURT
NORTHERN DISTRIC OF NEW YORK

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In re:

Case no. 07-11068

Highgate LTC Management, LLC,

(Chapter 11)

Debtor(s)

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SEVENTEENTH REPORT OF THE PATIENT CARE OMBUDSMAN FOR HIGHGATE LTC MANAGEMENT, INC.

For the Reporting Period Beginning December 15, 2009 and ending February 12, 2010

The following report is a compilation of information from three separate Long Term Care Ombudsman Programs due to the fact that this Bankruptcy proceeding involves three distinct counties each with a different Long Term Care Ombudsman Coordinator. Each Coordinator is submitting his or her own report in the name of Edie M. Sennett, the appointed Patient Care Ombudsman.

Report of Patient Care Ombudsman Activities for Northwoods Rehabilitation and ECF-Hilltop:

The Schenectady County Long Term Care Ombudsman Program continues to provide a regular presence in Northwood's Nursing & Rehabilitation ECF-Hilltop. The assigned volunteer Ombudsman remains vigilant keeping up her weekly visits to the facility in order to maintain the Program's regular presence in the building. The assigned Ombudsman has established a routine whereby she tours every unit and as prompted or needed has one on one conversations with residents and families during every visit.

A whole year has passed since the new administrator took over. After much planning and discussion some of the administrator's goals have finally been successfully implemented.

1. 12 residents went to the Holiday lights in Washington Park in Albany. The facility vehicle was used and two ambulates were hired. This is the first time that adult residents ever went on a trip outside of the facility. The administrator has been advocating for this since she arrived.

2. In early January a music therapist started in the facility. The therapist visits each unit and has individual sessions in the large room next to Physical Therapy. The music therapist is in the facility Monday, Wednesday and Friday.

3. Starting with the week of February 8th, the facility will be adding an art therapist. The art therapist will in the facility on Tuesday's and Thursday's.

Ombudsman attended the Resident Council meeting on January 21, 2010. Thirteen residents were present. The new Director of Housekeeping was introduced. At last months Council meeting, residents complained of the long delay in getting their personal laundry back once it went into the facility laundry. A new service is now in place and the staff is being oriented to the new procedure of separating the personal laundry from the facility linens. This new system should resolve this problem.

Residents continue to mention that response time for toileting is too long. Residents attribute this to a shortage of staff and suggest that additional staff be added to the morning hours due to the hectic morning routine. The Program will continue to regularly check with every resident when making rounds to ensure that call lights are being answered in a timely manner and are within reach. The Program has been instrumental in reminding residents that if their call light is turned off before care is given, that they turn their light back on until their needs are met. Both the Program and the administration are working together on this particular issue until the importance of answering the call lights promptly becomes effectively ingrained in the staff's minds.

The Ombudsman Program continues to play an active role with the administration and the social work department in assisting with issues involving residents care while in the facility and in coordinating their discharge plans. It has become routine that during every Program visit the Ombudsman and the facility administration confer with each other. Any concerns brought to the administrator's attention by the Program have thus far been rectified immediately and in some instances before the Ombudsman leaves the facility.

The physical environment in the facility continues to improve. The administration is constantly working on some project to enhance the appearance or improve the conditions of the facility.

The Ombudsman Program will continue to monitor the facility.

Report of Patient Care Ombudsman Activities for Northwoods Rehabilitation & Extended Care Facility of Cortland:

The Cortland County Long Term Care Ombudsman Program continues to cover Northwoods of Cortland with two volunteers and the Program Coordinator. The census has varied between the 180's and upper 190's. The following report captures observations and reported concerns from January 23, to February 11, 2010. Many of the issues as noted in the Interim Report submitted January 26, 2010 continue to be expressed by residents, families and staff. Complaints have increased over the past two weeks and have been communicated to the administration within the parameters of the ombudsman program. In addition to complaints received during facility visits, the ombudsman office received phone and email complaints on 1/27, 2/2, 2/4, 2/5 (2), 2/8 (2), and 2/10. These issues are consistent with those noted on the previous report.

Issues that have been observed and reported include:

- Staffing - As mentioned in the previous report, staffing continues to be the major concern and the most frequent complaint.
    - inadequate staffing levels
    - inconsistent staff (due to overuse of agency staff and staff from downstate facilities)
    - mandated shifts several times a week
    - staff attitudes

As a result of these complaints, it was reported that med errors are occurring due to nurses being tired, treatments are left undone or are done at midnight/1:00 in the morning. Several residents complained that medications were not administered or were given outside of the two hour window. It has been reported that residents have gone without showers. Residents report that when staff responds to call bells, the bells are turned off but the staff "takes a long time to come back". During the evening shift on 2/6/10, one resident was left on the toilet 30 minutes without access to her call bell. This resident called a family member to request that the family call the facility so care could be provided. The family member could not get through for 10 minutes due to the phone system going to automatic pick up. Several residents complained that the majority of the staff does not know their care needs due to staff inconsistency.

- Food Temperature – Complaints about cold food especially in the main dining room continue as noted in the previous report. This was discussed with the assistant administrator on 2/2/10. The facility will begin test trays to monitor this. There was a food council meeting scheduled for 2/09/10 however due to the Department of Health (DOH) conducting the annual survey, this meeting was changed to the resident council meeting with DOH.

- Safety – It is our understanding that there were two elopements over the past few weeks. The second occurred after a facility wide training regarding this matter. The resident had sustained an injury and was transferred to the hospital. He has returned to the facility.

- Personal mail – a family member reported that when they visited their loved one, they found unopened personal mail that dated back nine months lying on the dresser. Due to arthritis, this resident requires assistance opening envelopes. A policy was developed on 2/10 to address this issue.

- Transfer of information – A resident was admitted to the hospital on 2/9. It was reported that the resident arrived at the hospital without patient history because the copy machine at Northwoods was not working.

The Department of Health entered the facility for the annual survey on 2/8/10. The findings were unavailable upon the submission of this report.

Ombudsman Program recommendations continue as stated in the previous report:

- Suspend all admissions until such a time as the Patient Care Advocate is satisfied and gives notice to this court that the staffing levels can be met and stabilized with facility staff.

- Provide facility wide training and education in the areas of: 1) Resident Safety, 2) Standards of Care and 3) Customer Service.

- Set up family meetings to communicate goals and changes of the facility. This will also provide an opportunity for families to meet administration and become familiar with the processes in the facility.

Report of Patient Care Ombudsman Activities for Northwoods and Rosewoods Gardens Nursing Home:

Rosewoods Gardens Visits:

On December 23, 2009, the Coordinator visited the facility for a routine visit. The Coordinator observed a great deal of activity as the staff and administration were preparing for the facility's Christmas Party. The Coordinator spoke to the administrator regarding the facility's operation and all operations appeared to be appeared to be satisfactory. The Coordinator completed a walk through of the facility. During the walk through the Coordinator did observe one or two call bells ringing which were attended to immediately.

The Coordinator visited the facility on February 3, 2010 to deliver the Notice of Bankruptcy Report.

Northwoods Gardens Visits:

On January 5, 2010, the Coordinator visited the facility for a routine visit. The census posted on this particular day was 104 residents. The staffing levels for that day were as follows: 2 Nurse Managers, 7 LPN's, and 12 CNA's. The 3 PM to 11 PM shift had 1 supervising nurse, 7 LPN's and 1 CNA. The 11 PM to 7 AM shift had 1 supervising nurse, 3 LPN's and 6 CNA's. I spoke with the Social Director who had recently moved into the admission office and the admissions person who recently moved to a social worker position. Each social worker is now responsible for 60 residents. I spoke to the Resident Council President and she was pleased with this ratio as was the Administrator and the Director of Nursing. The Administrator also informed the Coordinator that the facility has hired an individual who will be providing musical therapy for the residents twice per week. The Coordinator toured the facility and did not observe any call bells going off. The Coordinator did observe that a few staff name tags were not visible; this situation was reported to the Nurse Manager and was immediately rectified.

The Coordinator visited the facility on January 26, 2010. The Coordinator visited with the Administrator and the Director of Nursing. The Coordinator toured the facility and all

operations appeared to be satisfactory. The Coordinator met with the Nurse Manager and staff on the second floor where no problems were noted. On this visit the Coordinator did not observe any call bells going off and staffing assignments were up to date on the status boards. Most staff identification badges were visible and the Nurse Manager corrected staff whose name badges were not visible.

On February 2, 2010, the Coordinator delivered the Notice of Bankruptcy Report to the facility.

The Coordinator visited the facility on February 5, 2010. The Coordinator met with the New York State Department of Health survey team. The Coordinator provided his observations and assessment of the facility to the survey team leader Pat McMahon.

On February 9, 2010, the Coordinator was invited to the survey exit interview conducted by the New York State Department of Health. The Department of Health presented a very favorable assessment and informed those assembled that the facility would be receiving a positive report. In fact, one member of the survey team stated, "We have really seen the improvement in the facility". This individual happened to be one of the members of the survey team that spent a lot of time during the time period (last summer) when the facility was placed in Immediate Jeopardy status by the Department of Health. The Coordinator has also noted a positive change in the facility since the new Administrator and Director of Nursing has been hired.

Respectfully submitted this 13th day of February, 2010

/s/Edie M. Sennett
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